YAKIMA WOMEN'S HEALTH,PLLC PATIENT DEMOGRAPHICS

PATIENT INFORMATION				☐Female ☐**MINOR**
Last Name: Apellido:		Responsible Party Name if Minor & Phone :		
First Name: Nombre:	MI:	SSN#:		Hm Phone: Telefono casa:
Address: Domicilio:	Date of Birth: Fecha de Nacimiento		Age: Edad	Wk Phone: Telefono trabajo:
City: Ciudad:	State: Estado:	ZIP: CP:		Cell Phone: Telefono celular:
Employer:		Occupation:		
Email Address:		Referring or Primary Care Physician:		
How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Radio ☐ Newspaper ☐ Yellow Pages **DEX** ☐ Yellow Pages **imPact** ☐ Previous patient ☐Other (specify)				
RESTRICTIONS: ☐ **YES** ☐ **NO** May we leave message(s) with anyone who answers your phone? ☐ YES ☐ NO If not, please indicate who we CANNOT speak with: Text Messages ? ☐ YES ☐ NO				
EMERGENCY CONTACT PERSON				
Last Name:	First Name:		Phone:	
SPOUSE INFORMATION				
NAME:	**DOB**:	SSN#:		
Place of Employment:	Contact phone #:			
PRIMARY INSURANCE INFORMATION				
Name/Relationship to insured :	Insured **DOB**:	Insured SSN#:	Employer:	
SECONDARY INSURANCE INFORMATION:				
Name/Relationship to insured :	Insured DOB:	Insured SSN#:	Employer:	

Patient No-Show / Cancellation Policy

This notice is to inform you that if you fail to give us a 24-hour notice of cancellation, for future appointments there will be a $20.00 cancellation fee billed to your account that is non-covered by your insurance. You will be financially responsible for this fee….

Signature: _____ Date: _____

Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum insurance benefits have been met and I agree to pay for services at full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

_____ _____
Signature of Guarantor Date

MEDICARE

LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for any services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.

_____ _____
Date Signature of Guarantor